NEUROTIC DISORDERS

A. GENERAL CONSIDERATIONS

Anxiety disorders are characterized by emotional maladjustment that may impair thinking and judgement but cause minimal loss of contact with reality. Anxiety resulting from the inability to resolve inner conflict is the common denominator of all neurotic disorders.

B. ESSENTIALS OF DIAGNOSIS

1. Anxiety

   a. Irrational fears.
   b. Sense of impending doom.
   c. Feelings of tension and sleep disturbances.

2. Simple Phobia

   a. Persistent and intense fear of a specific object or situation, such as high places, closed spaces, darkness, or animals.
   b. Sleep disturbances.
   c. Avoidance of the feared object or situation reduces the anxiety.

3. Conversion Disorder

   a. In a conversion reaction, an acceptable physical defect is substituted unconsciously for an unacceptable emotional conflict, e.g., a backache prior to starting a deployment.
   b. The patient has no voluntary control over thoughts or behavior.
   c. Compulsive act temporarily reduces the overt anxiety.

4. Dysthmia

   a. Prolonged depression persisting beyond reasonable expectation or inconsistent with the significance of the loss.
   b. Low level of activity, fatigue, and constant unhappiness.
   c. Suicide is a constant possibility; sudden disappearance of depression may precede a suicidal act.

C. LABORATORY TESTS

1. If available urine drug screen.

D. LABORATORY FINDINGS

1. Varies

E. COMPLICATIONS

1. Impaired ability to function.
2. Suicide.

F. TREATMENT

1. Prognosis is poor due to the long term nature of the problem.
2. If possible, remove the patient from stress situations.
3. Listen to the patient, venting may help relieve the anxiety. Do not be judgmental or suggest you can cure them. Simply listen and let them know you care.

4. Contact a Medical Officer for the use of tranquilizers during acute attacks.
5. Depression must be handled very carefully. Some of these patients may be suicidal. This patient must not be left alone. Contact a Medical Officer ASAP.

G. DISPOSITION

1. If the disorder is significant or interferes with their daily tasks, refer them to a Medical Officer.
2. Keep the significantly depressed and/or suicidal patient in sickbay. Consult a Medical Officer immediately. Once you are sure that no suicidal attempt has been made (ex. drug ingestion), MEDEVAC the patient. It is far better to error on the safe side and MEDEVAC a patient who is not truly suicidal than to miss one who may succeed at suicide in the near future.
3. Refer to the section on suicide.

PSYCHOSIS

A. GENERAL CONSIDERATIONS

Psychoses are a group of severe mental disorders in which the mental functioning of the individual is so impaired that it interferes with the individual's ability to cope with the ordinary demands of life. The principal manifestation is a loss of contact with reality. If due to drugs psychosis may be temporary.

B. ESSENTIALS OF DIAGNOSIS

1. Loss of contact with reality.
2. Bizarre behavior.
3. Delusions, hallucinations, and illusions.
4. Types of psychoses include.

   a. Schizophrenia

      (1) Affective disturbances, autistic thinking, loose thought associations, and ambivalence.
      (2) Delusions, hallucinations, and illusion.
      (3) Racing thoughts and speech.

   b. Affective disorders.

      (1) Severe mood changes ranging from happiness to extreme sadness without actual reason or precipitating events.
      (2) One mood extreme may dominate, or the patient may manifest alternating periods of mania and depression.
      (3) Feelings, thought content, and behavior will have the same tone.
      (4) Manic phases are characterized by enthusiasm, vigorous behavior, verbosity, and delusions of grandeur or persecution. Depressive phases are characterized by despondency, low self-esteem, profound sadness, withdrawal, insomnia, anorexia, and lack of personal care.

   c. Paranoid reactions.

      (1) Persistent delusions, usually grandiose or persecutory, that account for difficulties in mood, behavior, and thinking.
      (2) No defects intelligence.
      (3) No hallucinations.
      (4) Childhood history of needing special attention.

C. LABORATORY TESTS

1. NONE.

D. LABORATORY FINDINGS

1. NONE.

E. COMPLICATIONS

1. Suicide.
2. Loss of contact with reality poses a danger to both the individual and the command.

F. TREATMENT

1. Remove the patient from duties and place under observation.
2. Contact a Medical Officer concerning the administration of Haldol.

G. DISPOSITION

1. Contact a Medical Officer when you suspect patient is exhibiting symptoms of a psychosis.
2. MEDEVAC the patient as soon as possible.

SUICIDE

A. GENERAL CONSIDERATIONS

Transient thoughts of death and dying are universal, and thoughts of self destruction are common. The role of the IDC with respect to suicide is to have a high index of suspicion and to identify, guard, and refer those who have a suicide potential.

Suicide has many precipitating factors, but a common thread is a sense of deprivation of affection and love and a deep sense of personal rejection.

Many suicidal patients contact a clinician prior to their attempt. They may do this in a very subtle manner. It is, therefore, extremely important to recognize those at risk. The bottom line is that you should have a high index of suspicion and MEDEVAC any you suspect for a full evaluation per a Medical Officer.

ALL SUICIDE GESTURES/IDEATIONS ARE TO BE TAKEN VERY SERIOUSLY!!

B. ESSENTIALS OF DIAGNOSIS

1. Depression - underlying defect in most suicidal patients.
2. Substance abuse - alcohol, drugs. They increase the risk.
3. History of previous attempts increases the likelihood of suicide.
4. History of family member or close friend committing suicide increases the risk.
5. Recent significant emotional event - such as loss of a loved one.
6. Any suicidal ideations (written or verbal) should warrant evaluation.

    a. How often do they think of suicide?
    b. What specific means do they think of or plan?
    c. Have they planned a specific time when they will commit suicide?

7. Sudden reversal of severe depression should raise the suspicion of potential suicide.
8. Giving away possessions.
9. Onset of bizarre behavior.
10. Risk Factors: see chart at end of next page.

C. LABORATORY TESTS

1. None.

D. LABORATORY FINDINGS

1. None.

E. COMPLICATIONS

1. Completed suicide.
2. Injury from the attempt.

F. TREATMENT

1. Treat any existing injury from any possible or known attempt.
2. Place the patient under constant observation, MEDEVAC ASAP.
3. Remove and prevent access to a means of suicide (including dispensing any needed medications in single dose increments).
4. Evaluate for possible substance abuse.
5. Listen to the patient. Do NOT play down any complaints. Do NOT be judgmental. Just be supportive and a good listener.

G. DISPOSITION

1. MEDEVAC ASAP.
2. There is no reasonable explanation for holding a potential suicidal patient on board unless MEDEVAC is not possible.

RISK FACTORS

	Intensity of Risk		
Symptom	**Low**	**Moderate**	**High**
Depression	Mild	Moderate	Severe
Suicide Plan	No Plan	Occasional plan	Specific plan
Daily Functioning	Good in most activities	Moderate in some activities	Not good in any activities
Alcohol/Drug Use	Infrequent	Frequently to excess	Continual abuse
Anxiety	Mild	Moderate	High
Isolation	No withdrawal	Some withdrawal	Withdrawn
Previous Attempts	None	Some	Many
Coping Mechanisms	Constructive	Some constructive	Mainly destructive
Lifestyle	Stable	Moderately stable	Unstable
Close Relationships	Several	Few	One or none
Attitude Towards Psychiatric Help In Past	Positive	Mainly positive	Negative

See Enclosure 2